

KANSAS STATE BOARD OF PHARMACY
LONDON STATE OFFICE BUILDING
900 SW JACKSON ROOM 560
TOPEKA KANSAS 66612
(785) 296-4056
FAX (785) 296-8420

FEE: \$ 300.00

FOR OFFICE USE ONLY

REG NO. _____

DATE _____

APPLICATION FOR MANUFACTURER REGISTRATION

Print or type registration and physical address.

BUSINESS NAME OF OWNER

ADDRESS OF OWNER

CITY STATE ZIP TELEPHONE

Type of ownership is: _____ Individual _____ Partnership _____ Corporation _____ Other

IF PARTNERSHIP, attach additional listing of names and percentage of ownership.

IF CORPORATION, attach additional listing of officer and owners of stock.

IF OTHER, attach additional sheet indicating the type of ownership

The owner makes application for registration to manufacture drugs and/or controlled substances in the State of Kansas under the name of and at the following location?

NAME OF BUSINESS

ADDRESS

CITY STATE ZIP

CONTACT PERSON/AUTHORIZED REPRESENTATIVE TITLE TELEPHONE

MAILING ADDRESS FOR RENEWAL INFORMATION IF DIFFERENT THAN PHYSICAL LOCATION

CITY STATE ZIP

requests registration to manufacture drugs in the State of Kansas under the Pharmacy Act do hereby make application for registration covering the following drugs: (Check all that apply)

____ Legend Drugs _____ Controlled Substances _____ Nonprescription Drugs

____ Schedule I _____ Schedule II/nonnarcotic _____ Schedule II/narcotic

____ Schedule III/nonnarcotic _____ Schedule III/narcotic _____ Schedule IV _____ Schedule V

This application is being made for the following reason: (Check all that apply)

____ Original registration _____ Change of address _____ Change of ownership _____ Change of Business name

Is applicant registered by DEA to dispense controlled substances? _____

If Yes, please enclose a copy of the DEA certificate. If no, has an application been made to the DEA? _____

Has the applicant ever been convicted under any State or Federal law of a misdemeanor violation involving drugs or controlled substances or a felony? _____ Yes _____ No If yes, attach additional sheet explaining in detail.

Is the applicant presently registered with the Food and Drug Administration (FDA)?

____ Yes _____ No If yes, state the present FDA registration number and expiration date.

OWNER/CORPORATE PORTION

I, _____, solemnly swear (or affirm) that the statements and representations made in the foregoing application and all attachments are true and correct to the best of my knowledge and understands that this registration, if issued, will expire ANNUALLY on the 30th day of June and such registration will be cancelled if not renewed ANNUALLY by the 31st day of July.

SIGNATURE OF OWNER/OFFICER

Signed and sworn to (or affirmed) before me on _____ day of _____, 20_____

(Seal)

My commission expires _____

Signature of Notary Public

AUTHORIZED AGENT PORTION

I, _____, solemnly swear (or affirm) that the statements and representations made in the foregoing application and all attachments are true and correct to the best of my knowledge and understands that this registration, if issued, will expire ANNUALLY on the 30th day of June and such registration will be cancelled if not renewed ANNUALLY by the 31st day of July.

SIGNATURE OF AUTHORIZED AGENT

Signed and sworn to (or affirmed) before me on _____ day of _____, 20_____.

(Seal)

My commission expires _____

SIGNATURE OF NOTARY PUBLIC

THIS APPLICATION REQUIRES TWO NOTARIZED SIGNATURES. IF THIS APPLICATION DOES NOT HAVE TWO NOTARIZED SIGNATURES IT WILL DELAY THE PROCESSING OF THE APPLICATION.